WORLD HEALTH ORGANIZATION

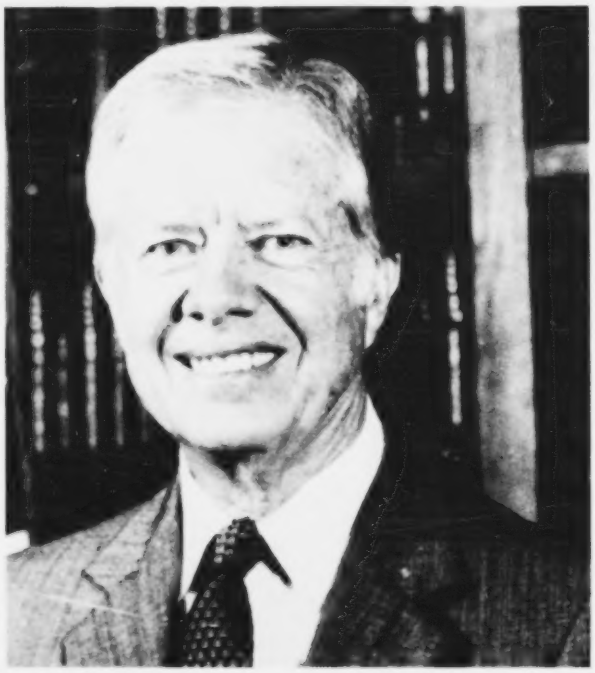
# TOBACCO ALERT

JANUARY 1991

## EDITORIAL

### CHILDREN AT RISK

Children represent the future. International leaders at the first World Summit for Children held this past September focused universal attention on the needs of children for the coming decades. Heads of state have pledged their support and committed their countries' resources to specific goals for improving the quality of life and health of children by the year 2000.



One of those goals has to be a decrease in tobacco use, which poses the most serious health threat for children and adolescents in the next century. Steps must be taken to outlaw the advertising of cigarettes and tobacco products and to discourage the use of tobacco. Some outstanding leaders have taken a stand and implemented programmes against tobacco advertising. Their courageous actions must be emulated by enlightened leaders of other nations. Even in the United States minimal efforts are made to restrict advertising or to ban sales of tobacco to minors. Most people who start smoking do so before the age of 19 and are easily addicted, many for life. This has resulted in approximately 390 000 deaths a year related to tobacco use in the United States alone.

The large multinational tobacco companies are now shifting their focus to developing countries. In these countries children and adolescents, along with women of childbearing age, are prime targets for sophisticated advertising and marketing campaigns. These children's lives are at risk. The tobacco companies are counting on these groups to increase their sales. The tobacco companies' efforts to entice and seduce children and adolescents into a lifelong addiction to nicotine is unpardonable. Heads of state must take a stand now to support advertising bans and marketing restrictions for tobacco. The health of the world's children, who are each nation's future, must become a global priority.

*Jimmy Carter*
*Chairman, The Carter Center*

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**'TOBACCO ALERT' WOULD LIKE TO WISH ALL ITS READERS A PROSPEROUS AND SMOKE-FREE NEW YEAR**

## SOCIETY

### ENVIRONMENTAL TOBACCO SMOKE EXPOSURE ON US AIRLINES BECOMES VIRTUALLY EXTINCT

In the past several years the efforts of US lawmakers to protect the public's health from the hazards of passive smoking have intensified. To date, forty-four States have enacted laws to curb smoking in public places, covering more than 80% of the US population. In addition, more than four hundred local jurisdictions have approved ordinances eliminating smoking from settings such as sports arenas and private worksites.

Clean indoor air policies affecting public transport are particularly strong. Amtrak, the national rail company, bans smoking throughout its trains except in a few smoking cars. Greyhound, the major American bus company, recently announced a smoking ban for all its routes. However, the nonsmoking policy that may have the greatest impact is the new legislation on air transport.

As of 25 February 1990, smoking was banned on all airline flights in the United States less than six hours in duration, affecting more than 99% of all domestic flights. The new law permanently expands previous legislation that banned smoking on all airline flights less than two hours in flight time. The success of the two-hour ban played a major role in expanding the law. During the first fourteen months

of the two-hour ban, only one hundred and thirteen violations were reported to the US Federal Aviation Administration, or about one for every four million airline passengers.

A preliminary source of information that provided the scientific backing for the airline smoking ban was the 1986 Surgeon General's report, "The Health Consequences of Involuntary Smoking". It reached three main conclusions:

- Involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers.
- The children of parents who smoke compared with the children of nonsmoking parents have an increased frequency of respiratory infections, increased respiratory symptoms, and slightly smaller rates of increase in lung function as the lung matures.
- The simple separation of smokers and nonsmokers within the same air space may reduce, but does not eliminate, the exposure of nonsmokers to environmental tobacco smoke.

In addition, the US National Academy of Sciences (NAS) conducted a study in 1986 relating to airline cabin environments. In its final report, "The Airliner Cabin Environment: Air Quality and Safety", the NAS endorsed a smoking ban on all domestic airline flights, concluding that a ban on smoking would "lessen the irritation and discomfort to passengers and crew, reduce potential health hazards to cabin crew associated with environmental tobacco smoke, eliminate the possibility of fires caused by cigarettes, and bring the cabin air quality into line with established standards for other closed environments."

Surveys have shown that both smokers and nonsmokers support airplane smoking restrictions. The 70 000 American flight attendants, who were a strong lobbying force for the new law, consider it to be a significant breakthrough which will improve their health and well-being in a confined working environment.

## NEWS BRIEF

### TOBACCO AND HEALTH: WHEN CHINA AWAKES ...

At the end of the May 1991, the Chinese Association on Tobacco and Health, in association with the WHO Collaborating Centre at Beijing, will hold a symposium on the damage tobacco does to health and on evaluation of methods for stopping smoking, including acupuncture. One hundred and fifty participants, including a score of foreign experts, will be invited to attend.

This initiative seems particularly welcome in view of a recent survey of the smoking habits of 2 379 Chinese teachers. It transpires that 64.4% of male primary teachers and 1.2% of female teachers smoke, which means that 21.7% of all teachers are smokers. There are more smokers among primary teachers than among secondary teachers. Most of them, however, do not smoke in front of their pupils.

In terms of legislation, China is poised to make up lost time with a discussion by the National People's Congress of a draft law on tobacco. This law will stipulate that health warnings against tobacco must be printed on the packaging of tobacco products, and it will ban the sale of tobacco to adolescents.

Finally, regarding communication, the Chinese Association on Tobacco and Health has decided that on the eve of the fourth World No-Tobacco Day, 1991, awards will be made to units that have distinguished themselves in campaigns against tobacco, and to cinema and television productions that allow no scenes in which the actors smoke. Other countries might learn from this example.

## NEWS BRIEFS

### PASSIVE SMOKING: A HISTORIC VICTORY FOR BRITISH ASTHMATICS

Although it has not been proven that tobacco smoke can cause asthma in non-smokers, there is no doubt that it aggravates the condition of those who already are asthmatic. Asthma is on the increase throughout the world, and atmospheric pollution is not unconnected with it; working in the same office as smokers can be a nightmare for asthmatics, for whom even minor irritation can cause great respiratory problems.

This fact seems to have been acknowledged by the British authorities, since the Commissioner for Social Security has upheld the complaint of an employee who claimed to have suffered six attacks of asthma between 1982 and 1986 because of the smoking of her colleagues in the office. The Commissioner did, however, emphasize that the decision had been governed by the plaintiff's extreme sensitivity to cigarette smoke, and should therefore not be taken as a precedent.

The anti-smoking organizations of the United Kingdom have seen, nevertheless, that this is a historic victory which could encourage the Government to take measures against passive smoking in the workplace.

Commenting on this event, Dr Donald Lane, of Oxford, Director of the National Asthma Campaign, said that asthmatics should immediately inform their employer of any worsening of their condition due to working in a smoky atmosphere.

Particularly worried by the effects of passive smoking on children, whether asthmatic or not, Dr Martin Jarvis of the Imperial Cancer Research Fund made the following point in The Times newspaper: "No one is going to pass laws about what happens in the home, which is probably the most important source of exposure for non-smokers".

### HEART ATTACKS AMONG YOUNG PEOPLE IN SOUTH-EAST ASIA:

Increasing numbers of young adults under the age of 40 are suffering heart attacks in South-East Asia. This emerges from a study made by the Cardiology Federation of ASEAN (Association of South-East Asian Nations), which consists of Brunei, Indonesia, Malaysia, the Philippines, Singapore and Thailand. There are, of course, many contributing factors to myocardial infarction: high levels of cholesterol and lipids, hypertension, diabetes, obesity, alcohol abuse, stress and family history of the disease are important ones. Nevertheless, the most common factor in all these countries would appear to be smoking. In the Philippines, for example, where 60% of men smoke, heart disease is now second only to communicable diseases as a cause of mortality. Although the relative importance of various other risk factors changes considerably from one country to another, it is striking that smoking is in each country at the top of the list. While cigarettes are not the only cause, they are the preponderant factor in the appearance among young people of a disease that had hitherto affected only people who were considerably older.

### THE DANGERS OF TOBACCO: IT ISN'T ONLY SMOKE ...

Each year, in Switzerland, some 5 000 fires are started accidentally. Smoking is directly responsible for 1 in 10 cases. The Information Centre for Fire Prevention has estimated that some SFR 20 million (approximately US$ 15.4 million) worth of damage is caused every year in the country by fires started by smokers. From half-extinguished cigarettes thrown in wastepaper baskets to the perilous habit of smoking in bed, the fire risks are many and various. Then there are forest fires, which have been in the headlines over the past few years, because of the series of exceptionally dry summers in Europe; we shall never know how many of them were started by cigarette ends thrown away by careless or unscrupulous smokers.

READEX

## EPIDEMIOLOGY

### TOBACCO-ATTRIBUTABLE MORTALITY: GLOBAL ESTIMATES AND PROJECTIONS

The massive global increase in cigarette smoking over the last few decades, particularly in developing countries, is of major concern for international public health. Estimates were needed not only of the current health effects of past smoking patterns, but also of the much larger future health effects of current smoking patterns. To take into account recent data and methods, the World Health Organization convened a Consultation on the Statistical Aspects of Tobacco-Related Mortality, which was held in Geneva in October 1989 (see "Tobacco Alert", April 1990). The principal findings of the WHO Consultative Group that are reported here are based not only on the October meeting but also on the subsequent application of methodologies recommended by the Group.

Both for developed and for developing countries, current annual mortality from tobacco (i.e. in the 1990s) is estimated. Next, estimates are given of future mortality from tobacco when the children of today are middle aged (i.e. after about 2025), and of the eventual total mortality from tobacco among all those alive today.

#### Delay between cause and full effect

One of the chief sources of misunderstanding about the health effects of tobacco is the very long delay between cause and full effect. The risk of lung cancer depends strongly on the exact duration of smoking, and among regular cigarette smokers in middle or old age those who started in their teenage years will be at much greater risk than those who started later in adult life. This means that a sudden large persistent increase in cigarette use by a particular generation of teenagers or young adults will have its full effect on mortality in middle age only when, a few decades later, that first persistently exposed generation passes through middle age (and it may have its full effects on mortality in old age only after a delay of several decades: see IARC Scientific Publication No. 74, 1986). Thus, current lung cancer death rates are strongly affected not only by smoking patterns 25 years ago, but also by the smoking patterns of teenagers and young adults 50 or more years ago. In the United States, for example, the large increase in male cigarette use between 1915 and 1945 resulted in a five-fold increase in age-standardized male lung cancer mortality during the 40-year period 1945 to 1985, even though there was no further large increase in cigarette use among American men after 1945. This pattern of a large increase in cigarette use followed, after a delay of several decades, by a large increase in lung cancer deaths has been seen in many developed countries and the recent very large increases in cigarette use in China and in many other developing countries are likely to produce comparable increases in male lung cancer during the early decades of the next century.

#### Other causes of death

Tobacco causes not just lung cancer, but also several other major diseases. In the United States, for example, where a large study of smoking and death has recently been reported, the US Surgeon General (1989) has estimated that in 1985 tobacco caused just over 100 000 deaths that were attributed to lung cancer plus just under 300 000 other deaths (the total caused by tobacco being about 400 000, or almost 20% of all US deaths that year). Thus, in the United States, tobacco probably caused almost three times as many deaths from other certified causes as from lung cancer.

The extent to which smoking is responsible for deaths from diseases other than lung cancer varies substantially from one population to another. (For example, smoking is particularly cardiotoxic for people who already have other risk factors such as high blood cholesterol, and it causes particularly large risks of cancer of the upper aerodigestive tract for people who already have other risk factors such as regular alcohol use.) But, the range of other diseases that can be caused by smoking is so extensive that the influence of other specific risk factors may effectively average out even in very different populations: for example, in many developing countries, although cholesterol levels are low (limiting the cardiotoxic effects of tobacco), a high prevalence of respiratory diseases may greatly increase pulmonary vulnerability to tobacco. ***The general conclusion that smoking causes many more deaths from other diseases than from lung cancer is therefore widely applicable.*** Lung cancer is, however, of particular statistical importance because among non-smoking populations the disease is so rare that high national lung cancer rates can generally be used as a measure of the combined past and present intensity of exposure to the hazards of tobacco.

#### Current effects of tobacco in developed countries

In recent years cause-of-death statistics that are reasonably reliable (at least in middle age) have become widely available for virtually all developed countries. Comparison of these national lung cancer rates with the rates among US nonsmok-

ers suggests that during the mid-1980s tobacco caused just under half a million lung cancer deaths a year in developed countries alone. Allowance for population growth (and for the changing lung cancer rates in various developed countries) suggests that it will cause just over half a million a year during the mid-1990s. Analogy with the United States, where tobacco kills almost three times as many people by other diseases as by lung cancer, suggests that in the mid-1990s tobacco will cause about two million deaths per year just in the developed countries of the world.[1]

Although more accurate information, particularly about the exact evolution of this epidemic, would still be very desirable, the order of magnitude of the current problem in developed countries has been reasonably reliably established: tobacco will cause about 20 million deaths during the last decade of this century. At present about four-fifths of the deaths from tobacco in developed countries are male, but in many of these countries female mortality from tobacco will eventually increase substantially due to the large increases in female smoking over the past few decades. More than half of these deaths occur at ages 35-69 years, making tobacco much the most important cause of premature death in developed countries.

### Current effects in developing countries

For most developing countries, the assessment of tobacco-attributable mortality is more difficult. Cigarette sales have increased substantially in recent years (much the largest absolute increase being in China), the male prevalence of smoking now exceeds 50% in many parts of the developing world (although the female prevalence is generally low), and chronic disease mortality rates are already high in many parts of Asia and Latin America. Overall, the group estimated that during the 1990s the annual number of deaths from tobacco in the developing world would be about one million (including some hundreds of thousands in China; and in India; and elsewhere), although this total is necessarily somewhat uncertain.

### World total in the 1990s

Taking both developed and developing countries together, the consultative group estimated that during the 1990s tobacco will be responsible for an average of about 3 million deaths a year worldwide, with a range of uncertainty of about 2-4 million.

### Future deaths from tobacco among those now under 20

At present, there are 2.3 billion children and teenagers in the world, and on current smoking patterns about 30-40 per cent (i.e. about 0.8 billion) will be smokers in early adult life. A large recent prospective study in the United States[2] indicated that, on average, persistent smokers have more than double the age-standardized death rates of lifelong nonsmokers. If smoking caused a two-fold excess at all ages it would eventually kill about half of all smokers. Not all the excess mortality associated with smoking is actually caused by smoking, however (though much of it is), the mortality ratio beyond 75 years of age may be less than two-fold, and in developing countries the death rates from some unrelated causes (e.g. infectious diseases) are higher than in the United States. So, in developing countries the proportion of persistent smokers eventually killed by the habit will probably be somewhat less than the proportion of about one-half that is suggested by the North American study. Even if the proportion is "only" about one-third, however, then about 250 million of these 800 million future smokers would be killed by the habit. Neither the accuracy nor the inaccuracy of this estimate of over 200 million deaths should be exaggerated.

If, on current smoking patterns, 200 to 300 million of those born in a 20-year period (e.g. 1970 to 1990) will be killed by tobacco, then at some stage towards the middle of the next century (when the majority of these deaths will occur) the average annual number of deaths from tobacco must be about 10 to 15 million, and at some earlier stage the average annual number of deaths from tobacco will therefore be about 10 million. The uncertainty is not whether, but when, the annual total will, on present smoking patterns, be about 10 million - perhaps in the 2020s, but perhaps not until the 2030s. If the epidemic grows as rapidly in other developing countries as it is likely to do in China then the date might be earlier rather than later: between 1978 and 1989 Chinese annual cigarette manufacture increased from 500 billion

*continued on page 7*

1 *A quantitatively similar overall conclusion for the 1990s can be reached by more complicated arguments based on analyses of the detailed age-specific, cause-specific death rates around 1985 for men and women in each developed country separately.*

2 *U.S. Department of Health and Human Services, 1989. "Reducing the Health Consequences of Smoking: 25 Years of Progress." Report of the Surgeon-General. Office on Smoking and Health, Washington, D.C.*

## HEALTH POLICIES

### THE ELEVENTH WORLD CONGRESS OF CARDIOLOGY AND TOBACCO

The Eleventh world Congress of Cardiology met in Manila, Philippines from 11 to 16 February 1990. It was presented with a set of recommendations for the control tobacco consumption by the Council of Epidemiology and Prevention of the International Society and Federation of Cardiologists.

It is now widely recognized that cigarette smoking is the most important cause of respiratory diseases, mainly lung cancer, in all industrialized countries. So far the medical community has not really assimilated that smoking is also one of the principal risk factors for arteriosclerosis and its most severe clinical events: angina, myorcardial infarction, stroke, intermittent claudicatio and gangrene.

The need for an intervention against smoking is based on the scientific evidence of its damage to health and of the beneficial effects seen after quitting. Statistics from some countries already show that if the number of smokers is reduced, the mortality rate is effectively reduced. Public Health expenses for diseases related to smoking and their subsequent disabilities would surely be more than enough to cover the cost of such preventive measures and even to make up for the loss of the profits derived from state taxes on tobacco products.

It is important to know exactly what does a cigarette contain and how our body is affected by these substances, especially by the most important ones such as nicotine, carbon monoxide, tar, etc.

The following may be considered an outline of a correct and pertinent information campaign on the deleterious effects of smoking on the cardiovascular system:

1. Nicotine greatly affects the cardiovascular system: it increases heart rate and both diastolic and systolic blood pressure; oxygen need by the myocardium is enhanced and arrhythmias are stimulated by nicotine while peripheral blood flow is significantly reduced.
2. Carbon monoxide has an affinity to human globin, especially to haemoglobin, many times greater than oxygen, thus blocking the function of a great fraction of haemoglobin and the transport of oxygen to tissues.
3. Tar is highly carcinogenic and like other irritant or toxic substances, such as benzopyrene, it favours chronic inflammation and cellular degeneration in the respiratory system.

XI WORLD CONGRESS OF CARDIOLOGY
Manila, Philippines 1990

It is in this perspective that the following recommendations for the Control of Tobacco Consumption were made by the Council on Epidemiology and Prevention of the International Society and Federation of Cardiologists to the Eleventh World Congress of Cardiology and adopted by the General Assembly of the ISFC:

#### ACTIONS

**Recommendations should be made to governments to:**

1. Progressively increase taxes on all tobacco products.
2. Prohibit direct and indirect cigarette advertisements.
3. Promote health education programmes.
4. Enforce the full application of the laws prohibiting smoking in public places, especially in schools and hospitals.
5. Induce tobacco industries to diversify investments.
6. Suspend all subsidies for tobacco production to producing countries.
7. Invite national and international organizations to adopt more active measures against smoking. That is most important since some tobacco producing countries, such as Italy, Greece, Portugal and Spain, are members of the EEC.
8. Prevent multinational tobacco companies (especially those based in the United Kingdom and the United States) from exporting and promoting cigarettes in Third World countries.
9. Make the sale of cigarettes to children illegal.
10. Demand that strong health warnings be placed on all cigarette packets.

**Recommendations which should be made to all heart foundations and societies ...**

1. Studies of the prevalence of smoking and other tobacco habits should be made regularly, especially in relation to cardiovascular disease.
2. Smoking rates in various sections of the population should be measured, particularly for doctors, medical students, children and women.
3. The burden of diseases due to passive smoking should be studied.

**... and to individual doctors**

1. Smoking habits of patients should be recorded routinely.
2. All patients should be advised to stop smoking, especially those who have had a heart attack or have other risk factors for cardiovascular disease.
3. Non-smoking should be the accepted practice in all health premises.
4. All health workers and particularly doctors should set an example by not smoking. Doctors are the most suitable persons to understand the negative effects of smoking on

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## NEWS BRIEFS

### THE UNITED STATES: DISPENSING WITH CIGARETTE VENDING MACHINES

Following Salt Lake City and Minneapolis, New York has banned cigarette vending machines from public places. The City Council decided by 33 votes to 1 to ban such machines from restaurants, theatres and bowling alleys, among other places; one exception is bars, as the measure is designed mainly to protect children and young people from the lure of the cigarette. This ban comes into force on 31 January 1992.

### WOMEN SMOKERS, BEWARE OF STOMACH CANCER!

According to a study recently published in the Archives of Internal Medicine, one woman smoker in 10 can expect to contract stomach cancer over the next 12 years. The risk is even higher for women who smoke more than 20 cigarettes a day. The authors of this study estimate that approximately 20% of the cases of stomach cancer registered in the United States of America are attributable to smoking. One more reason for deciding to give it up!

## Epidemiology (continued)

to over 1600 billion (more than a quarter of the world total), cigarette tar levels are high, case control studies in China show large effects of prolonged smoking on lung cancer, and the "background" death rates among non-smokers are already unusually high from diseases such as emphysema and cancer of the oesophagus (which suggests that among Chinese smokers the habit will cause particularly large hazards from these diseases).

### Future deaths from tobacco among those now aged over 20

If annual mortality from tobacco will rise from about 3 million deaths a year in the 1990s to about 10 million a year in the 2020s or early 2030s, then the average mortality over this 40-year period will be intermediate between 30 million and 100 million per decade. Since most of those dying from smoking over the next 40 years (plus some of those dying from it more than 40 years hence) are already adults in 1990, about 200 to 300 million of today's 3 billion adults can be expected eventually to die from tobacco.

### Eventual world total

Combining the estimates for those now under 20 and for those now over 20 years of age, the group estimated that on present smoking patterns about half a billion of the world's population today will eventually be killed by tobacco, and current experience in developed countries suggests that at least half of them will be 35-69 years of age when killed.

## Health policies (continued)

health. They themselves have to convince their colleagues who smoke to quit. It is a professional and a moral obligation, an inevitable example to the public and the best approach to discourage the new generations to acquire this dreadful habit.

The Eleventh World Congress also hosted a special workshop on the establishment of theme years of global education and awareness. According to Dr Gyarfas, Chief of the Cardiovascular Diseases Unit at WHO, WHO has consistently advocated the importance of informed opinion and public cooperation for improving the health of the population. This is linked to the rationale behind such themes as World Health Day and more recently, World No-Tobacco Day. Such efforts are aimed at raising awareness of an important public health topic so as possibly to change or modify behaviour In developing countries, for instance, it is still little realized that there is a link between tobacco smoking and cardiovascular disease, Dr Gyarfas said. If such concepts continue unchallenged, the Third World could be on the verge of a "tobacco epidemic". The mass media can undoubtedly assist in getting the message across to opinion leaders and legislators.

Appropriately, action on some of the key issues addressed by Dr Gyarfas had already been taken by the organizing committee and the Philippine host organizations - the Philippine Heart Association (PHA) and the Heart Foundation of the Philippines. For the first time the World Congress was formally declared a "no-smoking" event, and the cooperation of all delegates in this endeavour was requested. The hosts then developed this innovation by proposing a resolution to the ISFC General Assembly (held on the fourth day of the Congress) that future congresses should also attempt to prohibit smoking.

## LEGISLATION

### THE MARCH OF ANTI-TOBACCO LEGISLATION

WHO's Health Legislation unit continues to monitor national and subnational legislation on the control of smoking and other forms of tobacco use. Relevant international developments, for example instruments developed within the framework of the European Communities, are likewise monitored. Readers of "Tobacco Alert" are referred to the section devoted to smoking in WHO's quarterly journal, the International Digest of Health Legislation. We report below on some recent developments likely to be of interest throughout the world.

#### Brazil

An Order was promulgated by the Minister of Health on 31 May 1990. It introduces a number of stringent measures aimed at combating tobacco use. Included are the following measures:

- a prohibition on smoking in public and private health care establishments;
- a prohibition on the sale of cigarettes to minors;
- stringent restrictions on the advertising of cigarettes on radio and television;
- the inclusion of a health warning on packages of tobacco products (***"Warning from the Ministry of Health: Smoking is harmful to your health"***); and
- a recommendation that smoking be prohibited on all domestic flights with a duration of two hours or less.

#### New Zealand

On 28 August 1990, the New Zealand Parliament promulgated an important piece of legislation known as the Smoke-free Environments Act 1990. It has three clearcut objectives, as follows:

- to reduce the exposure of people who do not themselves smoke to any detrimental effect on their health caused by smoking by others;
- to regulate the marketing, advertising, and promotion of tobacco products, whether directly or through the sponsoring of other products, services, or events; and
- to monitor and regulate the presence of harmful constituents in tobacco products and tobacco smoke.

The Department of Health of New Zealand has issued a Guide to the implementation of the Act, from which the following are extracts:

***Supportive environment:*** One of the more effective ways of improving health status is by ensuring our social environment supports the making of healthy choices. By establishing nonsmoking as the norm, people will be less likely to think of taking up smoking.

***Healthy workplaces:*** Today there is an increased awareness of the importance of healthy workplaces. Particular equipment, processes and practices are potentially unsafe and this has led to specific measures to minimise the risks involved. In a more general sense, the workplace is the environment where many of us spend much of our waking time. The trend to the smokefree workplace is one aspect of a general emphasis on a health workplace.

***Management of change:*** Establishing smokefree working environments involves modifying the environment and changing attitudes. This is not a simple process and requires thought and sensitivity. The key principles are identical to those involved in any effective management of change - giving people a chance to become involved in the process, ensuring that there is time to adapt to any changes, and providing information about the reasons for proposed changes.

***Purpose:*** The purpose of Part One of the Act is to protect nonsmokers, or people who do not wish to smoke, from tobacco smoke in the environment. The Act does not aim to encourage active smokers to quit."

#### United States of America

On 24 May 1990, the United States Department of Health and Human Services issued a "Model Sale of Tobacco Products to Minors Control Act", this being recommended for adoption by States or localities with a view to preventing the sale of tobacco products to minors. The Introduction to this Model Act points out that access of minors to tobacco is a major problem in every one of the United States. Indeed, about three-quarters of the million or so outlets that sell cigarettes to adults also sell cigarettes to minors. These stores ignore the laws of their States because enforcement is almost non-existent. It is pointed out that over one million teenagers start smoking each year, and that minors buy about one billion packs of cigarettes each year. The Introduction goes on to point out that, because nicotine is an addictive drug, a minor who starts smoking is likely to be a lifelong customer - and one in four will die prematurely of lung cancer or other smoking-related disease. Illegal tobacco sales dwarf illegal alcohol and hard-drugs sales to minors, and the resulting mortality is many times greater - 390 000 deaths a year. These are, it is emphasized, preventable deaths, and many of them occur because youth can obtain tobacco products with ease. In fact, more than 80% of teenagers correctly believe that it is, at present, very easy for them to buy cigarettes.

One of the principal objectives of the Model Act is in fact to strengthen the enforcement of measures to eliminate easy access by minors to tobacco products and the resultant addiction to these products.

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*Design: WHO Graphics*

WORLD HEALTH ORGANIZATION

# WORLD NO-TOBACCO DAY

**31 MAY 1991**

*PUBLIC PLACES AND TRANSPORT: BETTER BE TOBACCO-FREE*

**Message from**
**DR HIROSHI NAKAJIMA**
**Director-General of the World Health Organization**

For a number of years now the World Health Organization has been pleading for societies free of tobacco, where not smoking is the social norm.

On the occasion of the two previous World No-Tobacco Days my messages to you conveyed my concern for the alarming situation regarding women and smoking and the dangers children and young people face growing up with the constant temptation to smoke, and affected by others smoking.

The slogan for 31 May 1991 will be: "Public places and transport: better be tobacco-free". While the warnings must remain, this Day can also be regarded as one of achievement and celebration. Victory can be claimed on many fronts; the figures are there for all to see. In many countries laws and regulations have been promulgated and smoking has been banned from a large number of public places and from public transport. Therefore, 31 May 1991 should also be a day on which each government and each local authority takes stock of progress in addressing the tobacco problem and looks at what still needs to be done to give all citizens equal health protection. The protection of non-smokers has progressed, but it has been no easy task! At last the smoking of others is universally acknowledged as being a major risk to the health of non-smokers. Studies on "passive smoking", some of them carried out by the WHO International Agency for Research on Cancer, have proved that the presence of carcinogenic and other substances in ambient tobacco smoke endangers the health of non-smokers.

Besides displaying politeness and normal consideration for others, refraining from smoking in public places and on public transport introduces a measure of prudence for hardened smokers, the real nicotine addicts, in that they stop for a short time. And this perhaps will convince them that it is possible to live without tobacco for increasingly long periods.

Thirty years ago "no spitting" notices were still very common in public places and on public transport in many parts of the world. Now we hardly ever see them. I hope that, in a similar way, the day will come when we shall no longer see "no smoking" notices, because it is the social norm not to smoke. It is in the hope that this will be soon that I am asking you to join with WHO in making active preparations for World No-Tobacco Day 1991.

**Hiroshi Nakajima, M.D., Ph.D.**
**Director-General**

# WORLD NO-TOBACCO DAY, 31 MAY 1991

The following information has been put together to support the celebration of the World No-Tobacco Day. It suggests activities to help promote the transmission of the message "Public places and transport: better be tobacco-free", all over the world. These activities need to be adapted to the culture and tastes of every country and every community: they could help generate other ideas and make 31 May 1991 another successful World No-Tobacco Day.

**The advisory kit for World No-Tobacco Day, 31 May 1991, contains the following:**

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**Message from Dr Hiroshi Nakajima, Director-General of the World Health Organization.**

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**What is a World No-Tobacco Day?**

Page 5
**World No-Tobacco Day event planner.**

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**Some facts for action — "Public places and transport: better be tobacco-free".**

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## We inform you, please inform us!

To improve the quality of the information material provided by WHO for future World No-Tobacco Days, we need your feedback. It would thus be much appreciated if you could forward to the WHO Tobacco or Health programme, after the celebration of the Day, a short description of the activities which have been organized in your country or region to mark the fourth World No-Tobacco Day. This description could be substantiated by pictures, posters and newspaper articles or any other material used. Some ideas for this evaluation are given on page 17. In addition, we will be glad to receive any official evaluation of the relevance and effectiveness of the information material forwarded by WHO for the occasion and the advice given through this advisory kit and the Regional Offices or the WHO Representatives.

# WHAT IS WORLD NO-TOBACCO DAY?

In view of the scientifically proven dangers of tobacco both for smokers and for nonsmokers who inhale smoke produced by others, WHO has committed itself to fighting this menace. World No-Tobacco Day, celebrated on 31 May each year, is intended to encourage governments, communities, groups and individuals to become aware of the problem and to take appropriate steps. In order to help them, WHO chooses a specific theme each year for thought and action. In 1990, the emphasis was placed on protection of children and young people, with the slogan "Growing up without tobacco". In 1991, we will concentrate on the problem of smoking in public places and on public transport.

## What is the message for 31 May 1991?

Too often in restaurants and waiting-rooms, at sporting events and on public transport, nonsmokers have to put up with the irritating fog of those who indulge their pernicious habit without regard for those around them. Whereas smoking alone in one's corner or in the open air without disturbing others may be a matter of individual free choice and a calculated risk endangering one's own health, it has to be said that forcing other people to breathe air that is vitiated by smoke is completely unacceptable, from the point of view of both health and common courtesy. Some smokers are aware of this and do their best not to impose their smoke on others, but there are some who could not care less about the discomfort they cause, which is inexcusable now that the ill effects of tobacco on the health of nonsmokers are beyond doubt and should be common knowledge. As a famous comedian once said, some people understand quickly but you have to give them long explanations ... The explanations have gone on for too long; it is time to use laws and draconian regulations to make the unwilling see reason. World No-Tobacco Day will therefore put across the message that everyone should have the right to breathe air untainted with tobacco smoke in public places and on public transport, and the authorities will be encouraged to legislate in this area where persuasion is not enough.

## How is the message to be conveyed?

The events organized for World No-Tobacco Day lend themselves to media reporting: they can be filmed, discussed in radio interviews, photographed or reported in newspapers and magazines. All the activities — distributing information, having drivers of municipal and national transport promote the Day, displays of posters or photos — can become media events as long as national and local media (television, radio, newspapers and magazines) are contacted in good time. All gatherings in public places or on public transport can be turned to advantage. The material distributed by WHO should be seen simply as a catalyst, a starting point for local activities whose only limits are the resources and talents of the local organizers. The aim is to inform not only the public but also decision-makers who could help combat smoking, especially along the lines of this year's theme.

## USEFUL QUESTIONS FOR THE PREPARATION OF WORLD NO-TOBACCO DAY

Once you have decided what type of event you want to organize to celebrate World No-Tobacco Day, consider how you are going to organize it.

**The following questions might be of use:**

**1**

What is our purpose in organizing this event?

**2**

How can we gain the participation of the greatest number of people?

**3**

What media representatives — from the press, radio and television — should we contact right now, to tell them about the activities planned for World No-Tobacco Day?

**4**

What items should we have made: writing paper and envelopes, letters for the use of the organizers, T-shirts, badges, bags?

**5**

How can leading figures in the community, managers of transport companies, heads of industry, and families help us organize and celebrate World No-Tobacco Day?

**6**

What celebrities might agree to participate?

**7**

How could the media help with advance publicity for World No-Tobacco Day?

**8**

How can the events be organized so as to enable the press to write articles about it or take photographs?

**9**

How can action be sustained after World No-Tobacco Day in order to create a greater number of no smoking areas?

**10**

How can our work for this year's World No-Tobacco Day help us prepare for 31 May next year?

# FACTS FOR ACTION

Tobacco kills at least 3 million people each year worldwide. In countries where smoking has been a long-established habit, about 90% of lung cancer deaths, 30% of all cancers and over 80% of cases of chronic bronchitis and emphysema are attributable to tobacco use as are some 20-25% of coronary heart disease and stroke deaths. Numerous other adverse health conditions including respiratory accidents, gastric ulcers and pregnancy complications are also attributable to smoking. The adverse effects of smoking on pregnancy range from low birth weight to increased incidence of spontaneous abortions, prematurity , still-births and neonatal deaths. Low birth weight is one of the strongest predictors of infant mortality. Other long-term effects on the child include impaired physical and intellectual development. Tobacco used in smokeless forms, e.g. for chewing, snuff taking, etc., is a major cause of oral cancer in countries, mostly in the Indian subcontinent, where the behaviour is widespread. Smoking materials are also a leading cause of many forest and residential fires and fire-related casualties.

## PUBLIC PLACES AND TRANSPORT: BETTER BE TOBACCO-FREE

Tobacco smoking is not only dangerous to the smoker but to nearby nonsmokers as well. Besides the acute effects of eye and throat irritation caused by exposure to environmental tobacco smoke, passive smoking increases the risk of lung cancer and possibly of cardiovascular disease in nonsmokers. Children are particularly sensitive to the damaging effects of enforced passive smoking.

In the face of these threats posed by smoking, there has been increasing pressure for worldwide action to protect the freedom of nonsmokers from the hazards to which they are exposed by smoking in public.

Governments, businesses, those running public transport services, taxi firms, and airlines are taking action to create greater protection and freedom for ordinary people to be safe from the risks inflicted upon them by the smoking of others. Featured hereafter are facts and figures from around the world which call for action to aid the promotion of more smoke-free public places and transport services.

## HEALTH EFFECTS OF EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE

**Environmental Tobacco Smoke (ETS) constituents. Mainstream cigarette smoke** is the smoke drawn through the tobacco into the smoker's mouth. **Sidestream smoke** is the smoke emitted by the burning tobacco between puffs. **Environmental tobacco smoke** results from the combination of sidestream smoke and the fraction of exhaled mainstream smoke not retained by the smoker. Important considerations in examining **the risks of involuntary smoking** (or passive smoking) are the composition of environmental tobacco smoke and its toxicity and carcinogenicity.

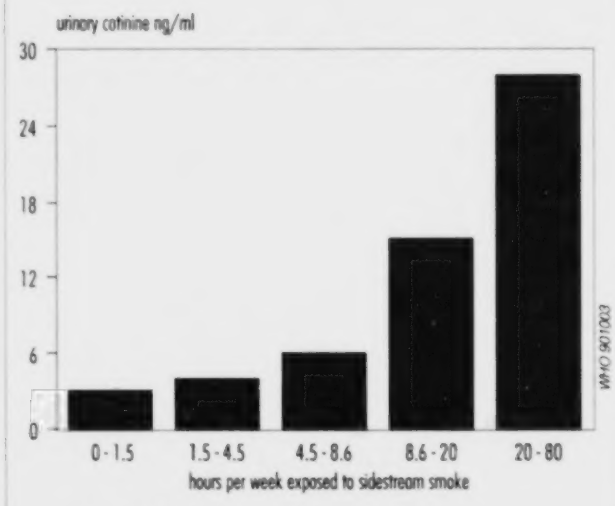
The comparison of the chemical composition of the smoke inhaled by active smokers with that inhaled by involuntary smokers suggests that the toxic and carcinogenic effects are qualitatively similar. Individual mainstream smoke constituents, with appropriate testing, have usually been found in sidestream smoke as well. The temperature of combustion during sidestream smoke formation is lower than during mainstream smoke formation so fewer of the toxins are burnt off. As a result, greater amounts of many of the organic constituents of smoke, including some carcinogens, are generated when tobacco burns and forms sidestream smoke than when mainstream smoke is produced. For example, in comparison to mainstream smoke, undiluted sidestream smoke contains roughly at least five times the carbon monoxide, three times the tar and nicotine, four times the benzo(a)pyrenes and forty-six times the ammonia as well as higher concentrations of many other noxious substances. Nitrosamines, which are potent carcinogens in animals, are present at higher concentrations in sidestream smoke than in mainstream smoke. Sidestream smoke also contains a greater concentration of nicotine decomposition products, benzene, carbon dioxide, volatile pyridines, nitrogen oxides, volatile amines and aromatic amines.

It is somewhat difficult to **quantify ETS exposure** purely in terms of cigarette equivalents because of the qualitative difference between mainstream smoke and ETS exposure. In addition the type and amount of tobacco used, room size, ventilation and filtration specifications, duration of smoking and background contaminants influence the measured concentrations of smoke compounds and their absorption by nonsmokers. However, ETS cannot be controlled by ventilation or air cleaning.

Passive smoking has been so commonplace in the United States that only about 15% of nonsmokers were not exposed; and this despite the fact that the US is relatively progressive in adopting restrictions on smoking to limit that exposure. People spending a long time indoors in sealed air-condi-

tioned buildings should be particularly concerned (see Figure 1). Naturally, the degree to which a nonsmoker is exposed to secondhand smoke varies greatly with the circumstances. For example, it is common for the equivalent of two to three unfiltered cigarettes to be inhaled each day by a nonsmoker in a smoky workplace. In poorly ventilated enclosures, the blood's carbon monoxide levels are greatly elevated compared to that of nonsmokers. A study has shown that after five hours in a smoke-filled hall, the blood level of nonsmokers possessed a level of cotinine, three times the level prior to exposure.

FIGURE 1
**A nonsmoker's absorption of nicotine**




Wald, et al., 1984 *The Health Consequences of Involuntary Smoking*, 1986

The **health effects** associated with exposure to environmental tobacco smoke can be summarized as follows:

- **Respiratory symptoms, signs and function**: Acute respiratory illness in early childhood; chronic cough, phlegm, and wheeze in children; chronic middle ear effusions in children; reduced levels and growth of lung function in children; reduced levels of lung function in adults; increased bronchial hyperresponsiveness (asthmatics); increased symptoms and decreased level of lung function in asthmatics
- **Irritant effects**: Eye, nose, throat
- **Malignancy**: Lung cancer
- **Childhood development**: Low birth weight; slowed lung maturation; decreased attained height

Furthermore, individuals with preexisting health conditions, such as asthma, bronchitis, cardiovascular disease, rhinitis, colds and allergies, often report more severe reactions to secondhand smoke than do healthy adults.

It should be remembered that nonsmokers are also exposed to the same occupational agents as are smokers. Certain chemicals in ETS may interact with other workplace toxins such as asbestos thereby endangering the nonsmoker. ETS substantially augments already existing indoor air pollution concentrations of RSP, benzene, acrolein, N-nitrosamine, pyrene, nitrogen oxides and carbon monoxide. Thus the effects of tobacco on health are often superimposed on the health effects of certain working conditions, making their cumulative effects even more dramatic.

## THE COST TO SOCIETY

In addition to the health effects, their related costs, and a combination of economic, environmental and behavioural factors contribute to make smoke-free public places and public transport a topic of significant importance to modern society.

Protecting the **environment** and the natural resources of the world is a global priority. While smoking creates unnecessary indoor air pollution, the millions of discarded cigarette packets, butts, filters and matches in buildings, towns and countryside spoil the physical environment. In calling for public places to be free from tobacco use WHO intends to protect the majority of people from exposure to the serious and preventable risks to their health that smoking entails but also to help reduce environmental pollution as a result of tobacco smoke and tobacco materials.

Furthermore, studies have indicated that in addition to the **high** medical costs occasioned by smokers, society is paying for **increased maintenance, ventilation and insurance costs**. Normal ventilation or air-conditioning is not enough to keep air smoke-free. How much air is reused, usually depends on energy savings to be gained by not feeding through fresh air which also then may have to be heated and humidified. Filters remove dust but not most of the cigarette smoke. The sub-micron particles and gases in cigarette smoke easily pass through filters used in normal ventilation and air-conditioning systems. These particles are then recirculated throughout the building. For small volumes of air, as in single rooms, there are more efficient filters available, e.g., carbon filters, but these are very expensive and need to be maintained frequently. Depending on the system, from 50% to as high as 90% of used air is recirculated. This air will be smoke-laden if there is smoking in the building.

### A healthy economic decision

Following the example of the Hong Kong Mass Transit Railway (underground) which has been totally non-smoking since 1980, Japan has made 114 of its 127 stations in the underground network smoke-free. The only stations not smoke-free are those located at ground level.

Smoking also increases litter and necessitates the more frequent renewal of decoration and furnishings.

Many **fires in public places** are attributable to smoking materials. The press has related the disastrous cases of fire started by smoking materials in hotels, restaurants, nightclubs and even forests, throughout the world. One of the largest, if not the largest fire caused by careless smoking in the world was in North East China in 1987. It raged for 25 days, killing or seriously injuring over 400 people, leaving 56 000 homeless and devastating 1.3 million hectares of land. Perhaps the most dramatic in recent years was that which occurred in the London underground (*see contents of box*). Following previous fires at other stations in 1981 and 1984 the London Underground had begun to offer more smoke-free accommodation: all carriages were declared smoke-free in July 1984 and 119 out of 263 stations smoke-free by 1985. The authority responsible for the underground service have now made their whole service smoke-free for the benefit of passengers and staff.

### The King's Cross Fire

In November 1987 thirty-one people were killed by fire in one of the worst underground railway accidents ever recorded. After 91 days of evidence the conclusion was drawn that: ..."The fire was started by smokers' materials dropped on the escalator. These smouldered among accumulated dirt and grease before spreading to wooden side panelling" (Financial Times, 25 June 1988).

London Underground made their whole service smoke-free shortly after the fire and has made other safety improvements since.

The underground is now also free from tobacco advertising and promotion, preferring the health and safety of its staff and passengers to the nearly US$ 600 000 (£300 000) it was paid in the past by the tobacco industry for advertising space.

To promote the smoke-free underground service, which has been well accepted by both staff and passengers, the London Underground publicized the dangers of smoking by means of press, radio and television; posters; "No smoking" signs on platforms; "No smoking" signs at entrances, in trains, lifts and escalators; cassette tapes broadcast over the public address system.

## FREEDOM FROM TOBACCO SMOKE AND THE LAW

The information featured above has shown that the control of smoking in public places and public transport makes good medical and economic sense, perhaps explaining why over the past few years there has been a rapid and profound change in society's attitude to public smoking. A wave of social action in the public and private sectors is redefining where and when it is unacceptable to smoke. Over the past 15 years, smoking in public places has been increasingly regulated by government action, largely by legislation at state and local levels. More recently smoke-free areas have also appeared in many countries in restaurants, hotels and motels, health care facilities and transportation vehicles. It should be emphasized that in all cases the regulations have been enforced with the intention of protecting health and not of punishing smokers.

The recent changes to make more of the world smoke-free are the result of two interrelated forces: **growing evidence about the health risks of passive (involuntary) smoking and changing public attitudes about the social acceptability of smoking.** Information about the health consequences of involuntary smoking has been accumulating for more than a decade, providing a strong rationale for policymakers' actions to regulate smoking. This evidence not only provided policymakers with a public health issue to address, but also attracted broad public attention via the news media.

However, data from opinion polls indicate that negative public attitudes about tobacco smoking had begun to develop before the health risks to nonsmokers were demonstrated. These negative attitudes, an important force supporting the growth in smoking restrictions, can be detected as early as 1964 in the United States; and since 1964 public opinion polls have documented the shift in attitudes about the acceptability of smoking. They documented a similar pattern of increasing support for smoking restrictions in the workplace.

These survey data indicate that in America people favour a higher level of restriction on smoking than currently exists. They also demonstrate that public support for smoking restrictions preceded rather than followed both the laws restricting smoking and most of the evidence about the health consequences of involuntary smoking (*see contents of box*).

## United States: A history of smoke-free places

At the state level, cigarette smoking has been regulated to a limited degree by state laws for nearly a century. The goal of this early legislation was to prevent fires or explosions by restricting smoking in such places as stables or factories. A second form of early state legislation was the result of a moral crusade against cigarettes coincident with the moral crusade against alcohol that emerged at the turn of the century.

By the early 1970s, a new form of anti-smoking legislation emerged, developed by the new nonsmokers' rights movement. The specific intent of these Clean Indoor Air Acts was the safety and comfort of nonsmokers. These laws covered a broader range of places and extended for the first time to privately owned facilities. The language became more restrictive, moving from permitting a nonsmoking section, to requiring one, to making nonsmoking the principal or assumed condition. In 1973, Arizona became the first State to restrict smoking in a number of public places, and the first to do so explicitly because smoking was a public health hazard. Although not comprehensive by current standards, the law was regarded as comprehensive when passed. The landmark event was the passage of the Minnesota Clean Indoor Air Act in 1975. This was the first piece of legislation to restrict smoking in a range of public places and to do so for health concerns. It became a model for other statutes, and the pace of new legislation increased.

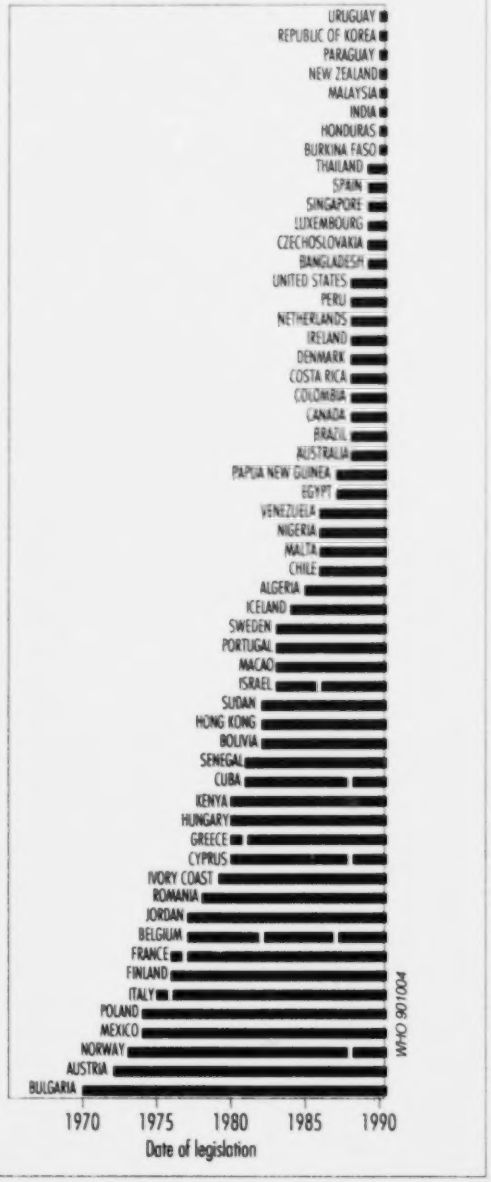
In many countries negative attitudes about smoking presumably contributed to the development of laws and regulations about smoking in public. At the same time, publicity surrounding the adoption of smoking policies may have increased public awareness of the hazards of passive smoke, thereby decreasing the acceptability of smoking in public. The development of negative attitudes towards cigarette smoke reflect a dislike of smoke exposure in addition to the main concern about publicized health hazards.

Freedom from tobacco smoking in public places is growing worldwide. Over half the countries in the world now provide protection from smoking in public places. There has been a rising tide (*see Figure 2*) of legislation to control tobacco use in public places, with much of it taking place since 1985. The law is an expression of political will and concern about risks to public health and public safety brought about by tobacco use especially in public places and in public transport. In some countries the evasion of laws by addicted smokers and others who do not respect the law remains a problem and further study is needed in the areas of education, implementation and enforcement.

The fact that over half of the countries in the world provide protection from smoking in public places encompasses a variety of public rights and public health and safety laws, however, it can be said that:

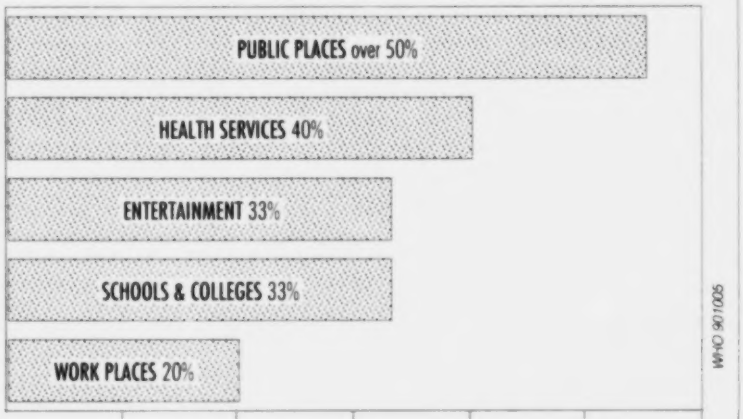
- Health services are protected in two-fifths of countries. This is the case for example in Belgium, Brazil (Rio Grande do Sul), Bulgaria, Colombia, Cyprus, Czech and Slovak Federal Republic, Hong Kong, Iceland, Norway and Vietnam.

FIGURE 2
**Rising tide of countries opting for smoke-free public places**



- Over one-third of countries have protection in entertainment establishments such as theatres and cinemas, e.g. Bangladesh, Jordan, Malta, Spain, Sri Lanka, Sweden, Turkey and Zimbabwe.
- Over one-third of countries have protection from smoking in schools, colleges (private and public) and in other government facilities, e.g. Chile, Finland, Greece, India, Israel, Netherlands, Panama, Romania, Saudi Arabia and USSR.
- At least one-fifth of countries provide some protection from smoking in places where people work, e.g. Australia and Finland.

**FIGURE 3**
**Worldwide protection from smoking in public places**




A graphic summary of the situation is presented in Figure 3.

Restricting smoking in public places and on public transport is a progressive move with each step leading to a reduction in the individual's exposure to ETS and an incentive for smokers to cease for a certain length of time and to progressively become non-smokers. The case of Singapore which started a policy of smoke-free public places in the early 1970s together with other tobacco control measures (see contents of box) has shown an encouraging overall decline in smoking prevalence, now at 13.6% among adults.

## Singapore goes smoke-free

Singapore has been promoting smoke-free public places since 1973. Successes so far include:

1973: Elevators, public buses, cinemas and theatres.

1982: Amusement arcades.

1988: Hospitals, maternity homes, medical clinics and nursing homes; indoor roller skating rinks and roller discotheques; fast-food restaurants.

1989: Public libraries including libraries in institutions of higher learning, public museums and public art galleries, any hall, ballroom or function room, which is air-conditioned and to which members of the public ordinarily have access, during such time when it is used for holding a meeting, conference, seminar, course or an exhibition or for the purpose of serving meals; air-conditioned supermarkets and air-conditioned mini-supermarkets; indoor sports arenas including sports stadia, bowling alleys, billiard saloons, gymnasiums and aerobic and fitness centres; air-conditioned restaurants; big department stores.

Singapore also has health warnings on tobacco packets which include:

"Smoking causes heart disease"
"Smoking causes cancer"
"Smoking damages your lungs"
"Smoking harms those around us"

## SMOKE-FREE PUBLIC TRANSPORT: A MODEL

Public transport was one of the first areas to benefit from anti-smoking legislation. This is probably due to the fact that the close confinement usually associated with public transport exacerbates the discomfort and risks entailed by smoking.

**Airlines flying smoke-free over 30 countries**: Tobacco smoke is one of the most common harmful air pollutants found indoors and even the air-conditioning of modern aircraft does not efficiently extract it. The filters become clogged with tar and small particles and much of the air is just recycled containing the carbon monoxide and many of the other toxic substances affecting all passengers and cabin crew, not just the smokers. Smoking on board aircraft is also a fire hazard. Many airlines are concerned about the resulting health and safety risks and have introduced smoke-free flights as well as smoke-free areas.

Smoke-free flights on domestic routes are provided by many countries such as Bahamas, Brazil, China (which has banned smoking on all internal flights since 1983), Cuba, Czech and Slovak Federal Republic, Fiji, Finland, Hungary, Japan, Malaysia, New Zealand, Papua New Guinea, Philippines, Poland, Portugal, Singapore, Thailand, Tonga, Turkey, Vanuatu and India.

Other countries provide smoke-free flights with time limits. Such is the case in the following countries: United States (all scheduled flights up to 6 hours or less in duration and all international airlines within the United States); USSR (domestic flights under 6 hours); Bulgaria, Iran, Israel, Korea, Saudi Arabia (flights of 2 hours or less); Australia (domestic flights within Australia and domestic components of all flights in Australia).

The following airlines provide smoke-free flights or substantial smoke-free seating: Air Inter, Icelandair, Virgin Atlantic Airways, SAS, Finnair, British Airways, Loganair, Linyeflyg, Trinidad and Tobago Airways, Cathay Pacific in Hong Kong and South-East Asia, North West Airlines (for the United States to Canada, Jamaica, Mexico and Cayman Islands), LOT — Polish Airline, OK Czech and Slovak Airline, Balkan-Bulgarian Airline (flights of up to two hours duration smoke-free).

In addition, on Air Canada, all transatlantic flights and all flights between Canada and the United States are smoke-free.

In a review of airlines using London Heathrow airport in 1990, most airlines said they had been looking at their smoking policies because of the concern voiced by passengers regarding health and safety risks. Most of the airlines surveyed said that any change they made to create more smoke-free flying would not affect their passenger turnover.

In summary, 30 countries now have a smoke-free service on all or most of their domestic flights; 15 airlines have a high proportion of smoke-free seats; some airlines request an agreement for all airlines to go smoke-free to reduce the unnecessary and significant threat to the health and safety of crew and passengers.

**Smoke-free buses, trains and taxis**: It is very often the responsibility of municipalities or local transport authorities or companies to decide on smoking privileges in **buses and trains**. It is thus more difficult to survey this area covering an innumerable number of specific cases. Nevertheless, more than 70 countries have buses or trains that are completely smoke-free or have smoke-free areas. These are:

**Africa:** Cameroon, Ivory Coast, Ethiopia, Ghana, Lesotho, Swaziland

**South-East Asia:** India, Myanmar, Nepal, Sri Lanka, Pakistan

**Americas:** Argentina, Bolivia, Brazil, Canada, Costa Rica, Colombia, Cuba, Chile, Mexico, Panama, 36 US States, Venezuela

**Eastern Mediterranean:** Cyprus, Egypt, Iran, Jordan, Libyan Arab Jamahiriya, Morocco, Sudan

**Europe:** Austria, Belgium, Bulgaria, Czech and Slovak Federal Republic, Denmark, Finland, France, Germany, Hungary, Iceland, Ireland, Israel, Italy, Malta, Netherlands, Norway, Portugal, Romania, Spain, Sweden, Switzerland, United Kingdom and USSR

**Western Pacific:** Australia, China, Guam, Hong Kong, Japan, Macao, Malaysia, New Zealand, Papua New Guinea, Philippines, Korea, Singapore

Should you wish to visit a country where all public transport is smoke-free by law or administrative decree, your destination should be one of the following: Cuba, Panama, Morocco, Sudan, Iceland, Israel, Malta, Romania, Malaysia and Singapore.

**Vehicles carrying children**, particularly school buses, are required to be free from tobacco smoke.

**Smoke-free taxis**: If you take a taxi in Norway, Colombia or New York you will have a smoke-free ride — your right and that of the driver to smoke-free air is protected by law. In Australia, nearly half of the taxi cabs display smoke-free signs although taxi drivers are allowed to smoke with the exception of Queensland. In London, taxis usually have a glass partition which can be used to create a smoke-free area for either the passenger or the driver. Nonsmoking passengers are making their views clear and we can expect to see more and more taxis smoke-free. Many drivers prefer it because it reduces damage to the interior of the taxis and the consequential cleaning.

## HOW TO PROMOTE A SMOKE-FREE WORLD

**Policies that regulate smoking in public places and public transport** stem from a collective consensus at the local, municipal, provincial or national level. While it is the role of governments to pass and enact legislation, the role played, to this effect, by individuals as part of society has proven important. Often, the responsibility still remains with the individual to pursue the establishment of further regulations to attain a tobacco-free society. Thus, each citizen, individually or in groups, should be concerned and try to make a conscious effort to play his role for a tobacco-free society.

### Personal environment

- Make your home a smoke-free place — get your family and friends to help.
- Choose to travel in a smoke-free area of trains, buses or other forms of transport.
- Ask for a smoke-free area when you go to the cinema, to eat or to play/watch sport.
- When you have no choice ask why smoke-free areas are not provided and suggest how it can be done.

### Neighbourhood and community

- Promote no-smoking areas in health services, cinemas, schools and colleges and your workplace.
- Promote no-smoking areas in all public places.
- Write to the members of your municipal council or parliament asking for their support.
- Promote support for existing laws and provisions for smoke-free facilities and tell people how much you like them: try to get the regulations/laws improved.
- Find out how many people locally support smoke-free services and create publicity for local ideas.
- Contact your local press, radio and television to get news and features on the benefits of a smoke-free life.
- Write to your local health services offering your support and ideas for promoting a smoke-free community.

**Promoting laws for a smoke-free environment**: Local regulations, laws, decrees, ordinances and bylaws can be used and may be the most effective in the short-term. Much of the current protection offered to nonsmokers worldwide is by local laws and regulations.

- Propose initiatives at country, state, county and local levels.
- Press for action to protect the health and safety of staff, the general public and most of all children; develop protection in health services, schools, government buildings, places of entertainment, sports centres, trains, buses, airlines, libraries, museums, banks, etc.
- Get to know the structure of the local laws and regulations (especially definitions of key terms) which have been used and the legislation adopted for your community. Find out about the means of **enforcement**, penalties, and the mechanism for implementing the laws, i.e. when the law is passed how it will be put into practice and who is responsible for making it work. A public education campaign, sign posting, and monitoring will be essential to make sure people know about the new measures and what they entail.
- Avoid ambiguity in the regulations and the sign posting.
- Work closely with those formulating the law and get examples of other relevant laws that have been implemented. Take advice from those concerned with health who have practical experience in the strengths and weaknesses of existing laws and regulations.
- Once the law has been adopted there is also a collective responsibility to monitor all stages of its implementation. After the effective date of the policy surveys should be conducted to see how well the measures are working at street level.

## RESPONDING TO THE TOBACCO LOBBY'S PROPOSALS

| Tobacco lobby's arguments | Smoke-free answer |
|---|---|
| "Consideration, not legislation." | Both are necessary. Regretfully, many smokers still impose their smoking on others, a threat to health and safety. The best response is when the freedom of people to breathe unpolluted air is backed by the law or other official support. |
| "Legislation infringes on the rights of smokers." | Smoking is a privilege, not a right. Freedom usually means being allowed to do what does not harm others. Creating smoke-free public areas is not an infringement of civic rights but a responsible health policy to prevent smoking damaging the health and safety of all people. Furthermore, many smokers want to change this behaviour and welcome smoke-free areas. |
| "It would take nonsmokers at least 4 days to inhale the equivalent of a single cigarette in a smoky atmosphere." | Tobacco smoke concentrations in buildings generally exceed the average air quality standards for clean air. The measurement of nicotine and carbon monoxide absorbed by nonsmokers exposed to tobacco smoke has quantified the risk for the nonsmokers in different circumstances. In addition, some cancer-causing chemicals, such as nitrosamines are much more concentrated in sidestream than in mainstream smoke. For example, in an editorial in the British Medical Journal (BMJ6135, 12 August 1978) it was concluded that being in a smoky room for one hour was the equivalent of smoking the cancer producing nitrosamines of 15 filter cigarettes. |

## BETTER BE TOBACCO-FREE

**Evaluating the impact of smoking policies** is an integral part of any action aimed at promoting a smoke-free society. Policies that regulate where smoking is permitted may have a number of direct and indirect effects which should also be considered in policy evaluation. In the short term, a policy that is adequately implemented and enforced will alter the behaviour of smokers in areas where smoking is prohibited. Such a policy should result in a reduced concentration of tobacco smoke and less passive smoke exposure in that area. Beyond these direct effects, there is the potential for smoking restrictions to have broader, indirect effects on smoking behaviour and on public attitudes regarding tobacco use.

The potential public health impact of smoking restrictions is vast. These policies, reinforcing non-smoking as the social norm, will be regarded as successful if they achieve their stated aim of reducing non-smokers' exposure to smoke. However, they will assume far greater public health importance if they are found to increase the cessation rate of smokers, and reduce the rate at which the young take up smoking. If policies do have these effects on smoking behaviour, they will make an important contribution toward reducing the prevalence of smoking in the world.

While celebrating the success already achieved in making public places and public transport smoke-free, it should not be forgotten that smoking kills a large number of nonsmokers in the world. These deaths are everyone's responsibility.

Primary sources of documentation: US Surgeon-General Reports, WHO Reports, documentation from the Environmental Protection Agency (United States) and the Institute for the Study of Smoking Behaviour and Policy, Harvard University Research.

# WORLD NO-TOBACCO DAYS: WHAT ARE WE ACHIEVING?

There is no doubt about the fact that every year the World No-Tobacco Day is achieving greater global success, with its celebration reaching more people and acquiring greater media coverage. This year WHO called on the celebration's participants to give a more detailed report of events in order to produce an evaluation of the day and the information is literally flowing in. The in-depth long-term evaluation will of course be the legislative measures taken as a result of the day and the number of people who ceased smoking for the day and continued to abstain. The number of people reached by the messages gives, in the interim, a good estimate of the efficacy of the measures taken for the celebration of the day. Here are some of the highlights of the information already received and some ideas on how to evaluate the effectiveness and long-term impact of a World No-Tobacco Day.

## A SELECTION OF SPECIAL EVENTS WHICH TOOK PLACE TO CELEBRATE THE THIRD WORLD NO-TOBACCO DAY, 31 MAY 1990*

### "Growing up without tobacco"

In analysing the reports received from all over the world it is interesting to see that some of the ideas adopted by various countries for last year's celebration have been used in other countries this year. We hope that the examples given below will help other countries plan future celebrations.

## AFRICA

### Mali

World No-Tobacco Day 1990 heralded communication between the Government Council and the Minister of Public Health and Social Welfare and the proposal to introduce measures for the protection of women, children and particularly adolescents against the dangers of tobacco consumption and for the introduction of health warnings on tobacco advertising.

The Minister for Public Health and Social Welfare announced, on radio and television, the incentives and objectives of the World No-Tobacco Day. The Minister qualified the position in Mali as being dramatic, a position marked by a worrying increase in the number of tobacco-related diseases and by little or no legislative measures to protect the population from this epidemic.

The video produced by WHO for the day entitled "Growing up without tobacco" was screened on television and throughout the day mini radio programmes inspired by the Health Information and Education Department were broadcasted in the national languages on numerous tobacco-related topics. A roundtable based on the theme of "Tomorrow's Mali against tobacco" was broadcasted on radio and television and featured many specialists from this field. The daily newspaper "L'Essor" published the Director-General's message for the day together with an article entitled "Clean up the social environment for the protection of children".

At the regional level conferences and debates were held on the theme of "Childhood and youth without tobacco".

### Nigeria

In addition to the usual celebrations and ceremonies held on the Day, the President of Nigeria, General I.B. Babangida, signed a new decree on 25 June 1990 aimed at combatting smoking. It includes restrictions on the advertising of tobacco products, the sponsorship of sports events by tobacco companies, and smoking in public places. Packages containing tobacco products must now carry the following (rotating) warnings:

— "The Federal Ministry of Health warns that tobacco smoking is dangerous to health".

— "Smokers are liable to die young".

Each package must also indicate the tar and nicotine contents of each unit of the tobacco product.

Severe penalties may be imposed on persons and commercial firms committing offences against the Decree, which is to come into force on a date to be fixed by the President.

* A more detailed analysis will be published by WHO in early 1991.

## THE AMERICAS

### Brazil

The Ministry of Health chose 31 May 1990 to promulgate Order No. 731. This provides for health warnings on the packaging of tobacco products, a ban on smoking on short distance flights, a prohibition on the sale of cigarettes to minors, and restrictions on the advertising and promotion of tobacco products, and other measures.

Furthermore, the theme of the Day was echoed by a press campaign which featured numerous reports and headlines.

### United States

In Washington, the celebration of the day was highlighted by the distribution of WHO Tobacco or Health medals to personalities such as Michael Pertschuk of the Advocacy Institute during a ceremony in Washington hosted by the Interagency Committee on Smoking and Health's National Committee. This meeting was chaired by the Surgeon-General of the United States, Dr Antonia Novello. In her opening remarks she said that on this year's No-Tobacco Day with the theme of "Childhood and Youth without Tobacco", her office was launching a new initiative entitled "Preventing the sale of tobacco to minors".

## EASTERN MEDITERRANEAN

### Kuwait

On the occasion of the third World No-Tobacco Day, the Department of Health Education, in collaboration with the Kuwaiti Society for Smoking and Cancer Control (KSSCC), implemented numerous programmes and activities covering anti-smoking areas and categories. A programme for celebrating the occasion was prepared. Government and private institutions participated through programme funding or implementation. Related activities and programmes were implemented during the two-week period from 26 May to 6 June 1990. A number of public and private symposia were held.

Relevant anti-smoking information and sensitization slogans were forwarded to all local newspapers and radio and television programmes at the beginning of May 1990, for use on World No-Tobacco Day 1990.

An anti-smoking sensitization brochure was printed. Three anti-smoking posters and slogans were designed by the Department and printed by KSSCC. One hundred and eighty cloth placards bearing sensitization slogans were distributed in public places, streets, marine and sports clubs and youth centres. The municipality of Kuwait distributed anti-smoking posters and placards for use in hospitals, health centres and streets.

A special television programme and eight short film "spots" featuring smoking hazards were prepared and transmitted by Kuwaiti television around the time of World No-Tobacco Day 1990. Various tips on smoking hazards were incorporated into television programmes such as the "Thursday Meeting", "The Friday Meeting", "The Children's Magazine", etc. A special news programme was also produced for the occasion. Relevant programmes and special meetings were transmitted on Kuwait's first and second radio channels for the duration of the anti-smoking campaign.

### Somalia

The WHO Representative in Somalia gave an interview to the press and television on the subject of tobacco or health. WHO information materials were distributed to different ministries, diplomatic missions and UN agencies in the country, and a speech on the harmful effect of tobacco was given by imams (religious leaders) in the city mosques.

## EUROPE

### Belgium

Great publicity was given to the Day in cinemas, the press and in the street. A special publication of the "Fondation contre les Affections respiratoires" was distributed to schools. A celebratory issue of "Spirou" was issued on the theme: Stop Before You Start.

### United Kingdom

From among other celebrations in Northern Ireland, the activities of the Ulster Cancer Foundation have been singled out. In recalling that WHO wants to encourage governments and all those concerned with the health and well-being of people to promote the concept of tobacco-free societies and non-smoking as normal social behaviour, the Foundation, in its role of Action on Smoking and Health (NI), marked the day by presenting the first ever "Smoke-free Awards" to two companies and one public agency who have each made a major contribution to the promotion of the concept of a "Smoke-free Society in Northern Ireland".

The awards went to: British Airways — In recognition of their introduction of a total ban on smoking on all domestic routes within the United Kingdom; Citybus — In recognition of the launch of a "smoke-free" Citybus service in Belfast; and to Western Group Environmental Health Committee — In recognition of their efforts and leadership in the campaign to eradicate the illegal sale of tobacco to minors in the Province.

Two young "Smokebusters" from the Province came to Geneva to participate in the celebration of the Day and to represent the Smokebusters clubs in Northern Ireland. Dr Nakajima, the Director-General of WHO, presented the Smokebusters with a Tobacco or Health medal. The two youngsters represent the 15 000 young Smokebusters in Northern Ireland.

## SOUTH-EAST ASIA

### Bangladesh

Various preparatory activities carried out a week before the Day included: Speeches by imams in city mosques on the ill effects of smoking. Being Friday there was congressional prayer. There was a press conference on the significance of the World No-Tobacco Day and a walkathon from the Shaheed Minar to the National Press Club. A television interview was given by Mr. Enayetullah Kha, Secretary General, ADHUNIK and Dr A.N.A. Abeyesundere, WHO Representative in Dhaka and was conducted by Professor N. Islam, the founding President of ADHUNIK.

On the Day the WHO representative joined a procession to the President's secretariat where a formal address of welcome was delivered by the Secretary-General of ADHUNIK. Three requests were placed before President Ershad:

1. A ban on tobacco advertisements in the printed media.
2. Increased taxation on tobacco
3. A committee for crop diversification.

President Ershad immediately announced his acceptance of all three proposals.

### Indonesia

Extensive media coverage was given to the issue of tobacco. A number of public places including hospitals, schools and offices marked the occasion by declaring them smoke-free as of 31 May 1990. Requests were made to the national airline "Garuda" to prohibit smoking on its short distance flights that day. Media representatives were briefed on the issue and press conferences were held on the Day involving Government, nongovernmental organizations and the WHO Representative.

A major event to mark the Day was a national one-day seminar organized by the Indonesian Heart Foundation which was officially opened by the Ministers of Health and Youth and Sports. Almost 300 representatives of many nongovernmental, youth groups, media as well as several important public personalities (singers, etc.) and young persons attended this seminar. Awards were given to several writers for producing the most informative and appropriate articles on the subject matter. A call for support from the Ministers of Information and Home Affairs was made by nongovernmental organizations.

Extensive television coverage of the subject was given for several days. The WHO film on tobacco or health was shown as well as a locally produced film, prepared especially for the occasion. In addition, the Health Education Bureau of the Ministry of Health produced and widely distributed T-shirts and pins.

## WESTERN PACIFIC

### China

On May 29 1990, a symposium on the third World No-Tobacco Day was held in Beijing by the China Association on Smoking and Health. The meeting was chaired by Dr Wu Jieping, the President of the association. The participants included Professor Chen Minchang, the Minister of Public Health, Dr Kean, the WHO Representative in China, the leading ranks of the State Educational Commission, the All-China Federation of Democratic Women and Communist Youth League of China, and many famous medical experts.

A meeting to exchange the successful experiences in anti-smoking activities was convened by the Beijing Smoking and Health Association on 30 May 1990. Representatives from the Beijing Railway Station and the Capital Gymnasium presented their successful experiences to make their lounge and gymnasium smoke-free. A model teacher from Beijing 79th Middle School reported her measures to cut down the smoking rates of its students. The President of the Association, Mr Bai Jiefu asked the Beijing Educational Bureau to urgently design a plan for decreasing the smoking rate in the primary and middle schools for a duration of three years. He also suggested that schools and hospitals should be the key units for smoking control.

Professor Weng Xinzi was interviewed by the special correspondent of the Beijing television station and asked to give a speech to the viewers about the importance of staging World No-Tobacco Days and the idea of strengthening the activities of the anti-tobacco campaign. The interview was broadcast on the evening news of Beijing television on 30 May 1990.

On 31 May 1990, nearly a million educational pamphlets were distributed to the public in the districts and counties of the Beijing Municipality. All shops were encouraged not to sell any kind of tobacco products for the day.

### The Philippines

On 31 May 1990, a campaign for babies born on the Day entitled "Born smoke-free" was initiated. The campaign received wide coverage, reaching even American newspapers.

A giant scroll bearing a resolution in support of a recent ban on smoking in the Department of Health premises was presented to Dr Alfredo R.A. Bengzon, the Secretary of Health of the Philippines.

## WHO AND THE UN SYSTEM

While the celebration in individual countries is the main purpose of World No-Tobacco Days, it is worth mentioning that WHO at headquarters and in the Regional Offices together with other agencies of the UN system have also had great pleasure in celebrating the Day.

The WHO Director-General's address delivered in Geneva during the distribution of Tobacco or Health Medals ceremony was quoted in many newspapers, particularly where he stressed: "If we are to have a smoke free society at the beginning of the 21st century we need to have the children on our side. In fact we need children and parents to be unified to meet the challenge together. In other WHO programmes we have already seen the influence of children in showing the way to health to their parents. We have also seen the success of health actions from adolescent to adolescent....".

To further support WHO action in the area of child education the Director-General of UNESCO addressed a message to the world on 31 May 1990, emphasizing that UNESCO's prevention and education programmes aim at reducing the craving for drugs by developing among young people the will to live without any dependency. Through collaboration between WHO and other concerned institutions he hoped that global education strategies would be established against smoking. Finally, he expressed his wish that the celebration of the day be a symbol of a society where children and young people will be happy to live without tobacco or any drug.

Finally, it should be emphasized that the celebration of the day was also very apparent at all the UN agencies, be it in New York, Vienna, Geneva or elsewhere. In Vienna, the VIC Catering Services generously donated small cakes and a strawberry sourmilk drink which attracted a large number of staff. Flyers were prepared on the basis of the WHO materials and printed at the expense of the UN/UNIDO Staff Welfare Fund. The Kreditanstalt, VIC branch, donated a large fruit basket featuring a wide selection of fruits as well as ball-point pens bearing the slogan: "Have 365 Healthy Non-tobacco Days".

## WHAT IS THE IMPACT OF THE WORLD NO-TOBACCO DAY IN YOUR COUNTRY?

### On an individual basis

Some countries have carried out an impact evaluation of this year's World No-Tobacco Day. In Norway for example this effect evaluation was made through a survey on a representative population sample two weeks after the day, and through extensive personal interviews made at random among daily smokers aged between 22 and 25 years one week after the Day. In summing up the results, it can be shown that 96% of the sample were aware of the existence of the Day and that one third of the smokers acted upon it. It also shows that the role of the media was very important and that the World No-Tobacco Day in Norway had received a remarkable degree of attention with ensuing discussions among families, friends and colleagues, and a pronounced behavioural reaction among smokers. An interesting evaluation could be to select a large sample of smokers and conduct a survey two weeks after the Day to investigate how many have ceased smoking and repeat this survey after one year and again at intervals of four to five years during the next ten to twelve years.

The second purpose of the Day, vis-a-vis individuals, is to propagate information on the harmful effects of tobacco. Consequently, another "impact evaluation" that could be done would be to estimate the number of people reached by the news and information disseminated during the day.

### On a municipal, provincial or national basis

At this level, it will be interesting to evaluate if the World No-Tobacco Day has triggered enough interest or has put enough pressure to warrant the passing of a law, bylaw, or regulation advancing the cause of tobacco-free societies. The attitude in major companies or public buildings (such as hospitals, schools or ministries) should also be considered.

Finally the following questions will be useful to complement the evaluation of the World No-Tobacco Day on a large scale.

Has your government improved the official policy or programme addressing tobacco or health on the World No-Tobacco Day?

Has the amount of money allocated to the implementation of this policy/programme been increased?

Has the enforcement of the anti-tobacco measures taken in your country been improved because of the World No-Tobacco Day?

Has public knowledge regarding the harmfulness of tobacco been improved on this occasion?

Has the social acceptability of tobacco decreased because of the World No-Tobacco Day?

Has the general attitude of the public regarding tobacco regulations been affected by the World No-Tobacco Day, if so how?

## FUTURE WORLD NO-TOBACCO DAYS

WHO sees future World No-Tobacco Days as opportunities, not only to ask people to stop smoking for one day, but also to initiate research on specific themes, publish information, and initiate action. Just a quick glance at the list of themes for future World No-Tobacco Days shows what course of action will be pursued.

If you have enjoyed reading this information for World No-Tobacco Day 1991: "Public places and transport: better be tobacco-free", perhaps you can help us prepare future editions of the advisory kit by sending material which could be the basis of our text. Here are the themes for the next World No-Tobacco Days.

1992: "Tobacco-free workplaces"
1993: "Health services, including health personnel, against tobacco"
1994: "The media against tobacco"
1995: "The economics of tobacco control"
1996: "Sports and the arts without tobacco"
1997: "The United Nations and specialized agencies against tobacco"

**Let's make the preparation for World No-Tobacco Day a global endeavour!**

## WHO SUPPORT FOR WORLD NO-TOBACCO DAY, 31 MAY 1991

**"Public places and transport: better be tobacco-free"**

In addition to the present information kit, the World Health Organization is planning to produce as background material for the fourth World No-Tobacco Day the following items:

- press releases;
- a video (12 minutes) on the theme "Public places and transport: better be tobacco-free";
- a press kit, containing articles, pictures, stickers and posters;
- radio recordings, to be made by various WHO experts on the subject of tobacco control.

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